NOVA SCOTIA
Department of Health

DEPARTMENT OF HEALTH

ANNUAL ACCOUNTABILITY REPORT FOR THE YEAR 2002-2003

105-06427/

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Annual Accountability Report for the Year 2002-2003

Department of Health

- Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2003, is prepared pursuant to the Provincial Financial Act and government policy and guidelines. These authorities require the reporting of outcomes against the Department of Health's business plan information for the fiscal year 2002-2003. The reporting of department outcomes necessarily includes estimates, judgements and opinions by department management.

We acknowledge that this accountability report is the responsibility of department management. The report is, to the extent possible, a complete and accurate representation of the outcomes relative to the goals and priorities set out in the Department's business plan for the year.

Orginally Signed by
The Honourable Angus MacIsaac
Minister of Health

Original Signed by
Dr. Thomas Ward
Deputy Minister of Health

Message from the Minister of Health

As Minister of Health, I am pleased to table the Department of Health's Accountability Report for the year 2002-2003. The Government of Nova Scotia and the Department of Health set goals and established priorities for 2002-2003 in our business plan and budget. The outcomes reported here show that we remain committed to those goals and priorities and do so at a cost which is sustainable for Nova Scotia.

I am proud of our many accomplishments in 2002-2003. Among our major achievements were:

Your Health Matters
The Department of Health released *Your Health Matters* - a multi-year plan focused on health promotion, improved access to doctors, nurses and other health professionals, shorter wait lists, seniors' care and health services within communities. Some of the funding announcements in the plan include: $5 million in 2003 to shorten the wait for cardiac care, and more money for medical equipment, mental health and hospital care.

Nursing Strategy
The Province continued implementation of the nursing strategy aimed at ensuring Nova Scotia has enough nurses in the future. Highlights in 2002-03 included the recruitment of more than 110 nurses from outside the province, new education programs, and the enrolment of 70 nurses in a new registered nurse re-entry program.

Mental Health Strategy
Nova Scotia established a strategic direction for mental health and is the first province in Canada to introduce formal standards to support this direction. There are standards in the five core mental health areas: promotion, prevention and advocacy; outpatient and outreach services; community mental health supports; inpatient services and specialty services.

Nursing Home Costs Reduced
The Department of Health developed a plan to make nursing home costs more affordable for Nova Scotians. The four-year plan will allow seniors to pay less each year for living in nursing homes, and eventually pay only for room and board. Other components of the plan include allowing seniors to protect more of their assets when calculating what they have to contribute to their care and a provincial investment of $8.5 million in continuing care in the 2003-04 budget.

Medical Equipment
New medical equipment was purchased for hospitals, including a new magnetic resonance imaging machine, new digital x-ray equipment, dialysis machines and bone densitometers. The federal government has announced another $30 million for medical equipment and the province will use these funds to continue to invest in wait time reductions for tests and treatments.

Stable Funding for District Health Authorities

The Department of Health secured a 10%($22.5 million) increase in operational funding for the district health authorities. The $22.5 million reflects the priorities of the government and Nova Scotians. This increase is in addition to the $65 million already set aside to cover wage settlements previously negotiated for nurses and other health-care workers. An additional 7% increase in districts' non-salary budgets was announced for 2003-04, and for subsequent years as part of government's commitment to multi-year funding.

Office of Health Promotion

The Office of Health promotion was created in December 2002 to give greater focus to improving the overall health of Nova Scotians. The Office's key areas of focus include: physical activity (sport and recreation), tobacco control, injury prevention, healthy eating, public health, addictions and healthy sexuality.

Smoke-Free Places

The Smoke-Free Places Act was put into effect in January 2003. This Act provides protection from tobacco anywhere there are youth under 19. Smoking is banned in places such as schools and school grounds, hospitals and clinics, malls, theatres, and taxis. In workplaces, restaurants and bars, smoking must be at minimum restricted to an enclosed, separately ventilated smoking room that only adults may enter, or to certain times of day.

Our vision is of "a dependable, caring health system that provides the right response by the right care provider in the right place at the right time". It is a vision of caring, responsive and quality service to Nova Scotians which is evidence-based and cost-effective. The accomplishments of my Department and of the entire health system in 2002-03 represent significant and encouraging progress in creating this vision of the future.

Introduction

This Annual Accountability Report for the Department of Health is based on the goals and priorities set out in the Department's business plan for 2002-2003 fiscal year. This report should be read in conjunction with the 2002-2003 Business Plan (available on the Department of Health web site at http://www.gov.ns.ca/health).

The report is structured in tandem with the Business Plan and details key departmental and health system accomplishments for 2002-2003, financial performance, and health system performance measures and outcomes.

Through leadership and collaboration, to promote, maintain and improve the health of Nova Scotians and ensure an appropriate and affordable health care system.

This is the mission of the Department of Health. The Department is committed to the ongoing improvement of our health care system through system planning, legislation, resource allocation, policy and standards development, monitoring and evaluation, and information management. Accordingly, the Department fulfills its mission by:

- *setting the strategic direction for the health care system and developing provincial plans, policy and standards which enable accountability and support that direction;*
- *providing funding to health authorities, physicians and other health service providers in the provincial health system;*
- *monitoring, evaluating and reporting on performance and outcomes across the health system; and*
- *ensuring quality health services are available for Nova Scotians.*

The Department of Health has identified three "critical to mission" criteria against which all proposals for new and expanded programs and all existing programs and services are evaluated.

Our Mission requires that all health care and services be:

- **Integrated**
  An integrated health system ensures the coordination of services and allows providers to work together to improve the health status of the population.
- **Community-Based**
  A community-based health system assures input by communities in planning and identifying strategies and services to improve the health status of the population and ensures that teams of providers participate in carrying out these strategies and services.

- **Sustainable**
  A sustainable health system is one that is accountable for providing quality services to the population it serves and is affordable in the long term.

Core Business Areas

The Department of Health had 7 key areas of care and service delivery in 2002-03[1]. These are briefly outlined below:

Population Health and Primary Health Care

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practice, individual capacity and coping skills, human biology, early childhood development, health services, culture and gender. The goals of a population health approach are to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups.

Primary health care is concerned with all the factors that promote health as they apply to a given population, not just personal health services. It addresses the factors that determine health. These include things such as income, social status, social support networks, education, employment, working conditions, social environment, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture. These factors are recognized and addressed within a system that has appropriate linkages, both with other components of the health care system and with all other related sectors and aspects of provincial and community development, such as community groups, family caregivers, volunteer organizations, government departments and agencies, and others.

Primary health care is developed with the full participation of the people it serves. It empowers people to take care of their own health and to take an active part in planning, policy making, and delivering health services in their community. Primary health care requires a strong foundation of community-based services that enable people to maintain and strengthen their health. Primary health care services include health education and promotion, prevention, rehabilitation, and support and treatment for illness and injury.

Primary care is one aspect of primary health care. It is the individual's or family's initial and continuing contact with the health care system. The focus of primary care is on service delivery. Primary care services include health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, education and advocacy.

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[1]Organizational realignments in the Department of Health will result in some minor changes to the configuration of Core Business Areas for 2003-04.

Population Health and Primary Health Care provides leadership, direction and support to the following services:

Addiction Services comprise a menu of components that are available according to the individual's needs and readiness. Services are delivered by the DHAs and include:

- Withdrawal management (detoxification) and addiction education program;
- Community based programs (outpatients) and structured treatment;
- Prevention and community education (in schools, workplaces and communities); and
- Problem gambling (specialized services including prevention and education).

Tobacco Control works in partnership with many other groups to implement a comprehensive tobacco strategy for Nova Scotia. Elements include taxation, legislation, treatment/cessation programs, community-based programming, youth smoking prevention initiatives, media awareness and evaluation.

Public Health Services are delivered to Nova Scotians through the DHAs. The staff work in partnership with communities, families and individuals to prevent illness, protect and promote health and achieve well-being. Activities are directed at an entire population, priority sub-populations or individuals, in some circumstances. Major functions include population health assessment, health surveillance, population health advocacy, health promotion, disease/injury prevention and health protection.

A new Office of Health Promotion was announced in December 2002, and commenced operations in early 2003.

Primary Health Care provides policy and planning support to re-designing a community-based primary health care system for Nova Scotia. Changes might include: increasing the number of community based primary health care organizations, more interdisciplinary teams, better linkages to other parts of the health care system and increased emphasis on health promotion. The currently operating Strengthening Primary Care in Nova Scotia Communities Initiative is piloting new ways to fund, deliver and manage primary care in four Nova Scotia communities using collaborative practice between nurse practitioners and physicians, electronic information systems and alternatives to fee for service payment for physicians.

Mental Health Services

Mental Health Services are funded by the Department of Health and delivered by nine DHAs and the IWK Health Centre. These Authorities administer a network of 50 community-based clinics, inpatient beds, day treatment centres, club house psychosocial rehabilitation programs, and drop in centres. These services are part of a continuum of treatment that is provided to individuals across the life span and is community based and consumer and family focused.

All District Health Authorities and the IWK Health Centre offer acute and longer term treatment and support. Specialized services are offered in some jurisdictions (e.g., forensic, sex offender treatment, neurodevelopmental delay, early onset psychosis, mood disorder treatment, eating disorders, psychosocial rehabilitation and psychogeriatrics,).

Acute and Tertiary Care

Acute or hospital care is comprised of secondary and tertiary care services delivered by the nine DHAs and the IWK Health Centre. Acute Care is delivered in thirty-seven (37) facilities which are governed and managed by the DHAs. Funding is provided by the Department of Health in accordance with the *Canada Health Act* and the *Nova Scotia Health Services and Insurance Act*.

Each district has community and district facilities with services which vary according to the type and level of emergency care provided, the hours of operation and access to ambulatory care provided, and the type and level of service provided to their inpatient populations. Inpatient services range from general practitioner services at the community facility level through to varied specialist services at the district level. Specialist services in district hospitals may include Cardiology, Respirology, Gastroenterology, High Risk Obstetrics, Otolaryngology, Orthopaedics, Ophthalmology, Pathology, Psychiatry, Pediatrics, Urology, Plastics, Maxillofacial Facial Surgery, Oncology, Neurology, Dermatology and Endocrinology.

The Queen Elizabeth II Health Sciences Centre and the Izaak Walton Killam Hospital in Halifax provide specialized services such as Neurosurgery, Specialized Pediatrics, Burn ICU, Cardiac Surgery, Transplantation Programs, Cardio-Thoracic Surgery, Immunology and Hematology, as well as all the services available in the community and district facilities. The centres also provide the highest level of emergency services.

Insured Health Programs

In addition to hospital services, the Department of Health also funds medical or physician services for Nova Scotians under the terms of the *Canada Health Act* and the *Nova Scotia Health Services and Insurance Act*. Under the legislation, insured physician services are those services which a qualified and licensed physician deems are medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern.

Other publicly funded health programs include Seniors and other pharmacare programs, a children's dental program, and other services for specific populations such as optometry, prosthetics and dental surgery.

Emergency Health Services

Emergency Health Services (EHS) is the division of the Department of Health which is responsible for the continual development, implementation, monitoring and evaluation of pre-

hospital emergency health services for the province. Since 1995, the ambulance system has undergone a transformation from primarily a transportation system to a pre-hospital medical system with a province-wide fleet of well equipped ambulances. The ambulances are staffed by registered paramedics who perform life saving procedures and can administer a wide range of medications.

The main components of EHS are a communications centre (including 911), a ground ambulance service, an air medical transport program (EHS LifeFlight), a provincial trauma program, and the Atlantic Health Training and Simulation Centre. All system components are monitored by physicians specially trained in emergency care.

Continuing Care Services

Continuing Care is a system of delivering an integrated continuum of health and social services to support the independence and well being of individuals with an identified need. Services include: nursing homes, homes for the aged, residential care facilities, small option homes, community residences, adult protection, home oxygen, and acute and chronic home care services. In most cases, the need for care and support is long term, however, short term needs are also met through the home care program. The Department of Health is primarily responsible for services to seniors but younger adults are also served through our nursing homes, home care services and adult protection programs.

The Continuing Care Program has three main components:

- Administration - Provides executive and operational management functions for Continuing Care services including planning, budgeting, human resource and support activities;
- Assessment/Coordination Services - Performs intake, assessment, service planning, resource authorization and ongoing case management functions on behalf of Continuing Care clients, ensuring that appropriate services are identified, implemented and monitored; and
- Care Services - The health care and support services available to individuals through Continuing Care programs include nursing care, personal care, home support, rehabilitation, respiratory therapy services, palliative care and respite. Care may be provided in a client's home or in a facility where the client is accommodated.

Provincial and Other Health Programs

The Department of Health funds a number of arms-length agencies which plan and coordinate service delivery and standards setting to ensure consistency and quality of care and service delivery. Agencies such as Cancer Care Nova Scotia, the Nova Scotia Trauma Program, Diabetes Care Nova Scotia and the Reproductive Care Program bring together experts in care provision to establish standards based on best practice, research evidence and stakeholder input. Through these agencies, strong networks of professionals participate in the rapid transmission

and uptake of new knowledge and standards. Data are collected to enable monitoring of compliance with standards and outcomes of service delivery.

In keeping with its mission, the Department also provides grants and funding to a variety of agencies and organizations across the province to provide advocacy and specific health related services to targeted populations.

Priorities and Departmental Accomplishments for Year 2002-03

Goal: **Design and implement a plan for continuing care which addresses integration, sustainability and accountability.**

Priority	Departmental Accomplishment
Implement single entry access (SEA) to home care, long-term care and adult protection services across Nova Scotia. SEA begins with client intake through a single toll-free telephone number and is supported by an integrated and automated information management system for intake, assessment and wait list management functions. SEA will make it simple and fair for people in need of care and their families to access the right level of care.	Single Entry Access is a process that helps Nova Scotians connect with home care, long term care placement or protection for vulnerable adults through a single toll-free telephone number. They are connected with professional care workers, qualified to determine what level of care best meets the needs of each individual - and ensures that those who need care most, receive care first. Early evidence shows that this approach has slowed the rate of increase in people waiting for long term care placement. In fall 2002, Nova Scotia became the first province in Canada to implement the RAI-HC (Resident Assessment Instrument - Home Care) assessment tool province-wide and the first province to augment this tool with an automated intake function and managed waitlist for long-term care facilities. Also, Nova Scotia has implemented an automated service plan. This integrated software is named SEAscape.
Develop and apply a rigorous and evidence-based methodology for determining the optimum size, scope, contribution and distribution of continuing care services across Nova Scotia (Health Services Planning, Phase II).	An analysis of long-term care, home care and other continuing care services was undertaken in 2002. Benchmarks for various services were developed and shared with stakeholders. Twenty-seven existing classifications of continuing care were grouped into six categories for planning purposes. A written document, with an updated inventory of services and projections to 2016, will be published in 2004.
Build capacity among current long term care providers for dealing more appropriately and effectively with resident behavioural issues.	Nursing home residents with aggressive or challenging behaviours can hurt themselves or may hurt people around them. Comprising representatives from across the province, the Challenging Behaviour Working Group has developed recommendations for a comprehensive and integrated approach to the care of people who display difficult behaviours in long term or home care settings. Recommendations included appropriate staff training and other resources and supports. Consultations on these recommendations began in February 2003.

Priority	Departmental Accomplishment
Develop and implement an approach to predicting and managing home care service growth through contracted agencies which ensures the continued sustainability of the home care sector.	The Department of Health worked with the continuing care sector and other system partners data collection through a decision support system, acknowledging demographic predictions and educational requirements. With an overall nursing shortage and a workforce comprised of mostly casual employees, the challenge is to retain skilled staff in the home care sector. Work began on developing an audit and monitoring process for checking resource allocation against service delivery and evaluating the Single Entry Access system for home care.
Develop an appropriate, consistent and equitable funding formula for the residential long term care sector.	The residential long term care system is funded on a per diem basis. Interdepartmental work on a system-wide approach to the long term care sector began. This work will enable the development of a funding formula for this sector.
Develop and implement a process to transfer service delivery of the departmentally administered home care programs to the governance and administration of the DHAs.	The transition of the home care program is complex, involving the transfer of employment of staff from the Province to the DHAs. The transition planning process will include, among other things, consultation with those individuals impacted by the transition. Transition dates have not been determined.
Develop and implement a process for the integration of the Department of Health's long term care sector with the DHAs through the establishment of affiliation agreements.	A planning committee has developed the principles for an affiliation agreement that would provide a framework for the working relationship between the DHAs and the nursing homes and homes for the aged, in their respective districts. Ownership and governance of the homes will not change.

Goal: Develop and implement a broad based health human resource strategy.

Priority	Departmental Accomplishment
Develop, pilot, recommend and oversee implementation of a comprehensive physician resource plan for Nova Scotia. The Physician Resource Planning Steering Committee has a mandate to develop and apply a rigorous methodology for determining the optimum number and geographic distribution of physicians by type of services (general practice and specialities) and by level of service (primary care, hospital-based, academic, etc.)	Nova Scotia's Physician Resource Planning Steering Committee, with representation from the Department of Health, physician and academic communities, the Medical Society of Nova Scotia, the Dalhousie Faculty of Medicine, the Nova Scotia College of Physicians and Surgeons, the DHAs, and the IWK Health Centre, has developed a flexible approach to physician service planning across the province. This plan attempts to achieve reasonable access to doctors in rural and urban areas now and into the future, and will be supportive of recruitment and retention efforts. Consultations on the approach and application will be carried out during 2003-04, leading to the implementation of a provincial physician resource plan. Additional work in the area of physician resources included: • the Department of Health worked with the Dalhousie Medical School on a proposal that could streamline the time it takes for international trained specialists to have their qualifications assessed. Work is ongoing. • the government and Dalhousie University worked on developing a long-term plan that would see more doctors trained in Nova Scotia. Eight new undergraduate student positions were approved for the Dalhousie Medical School over the next four to five years. Currently Dalhousie Medical School enrols 82 undergraduates annually and trains approximately 435 residents. • consultation took place on a bursary or sponsorship for doctors who agree to practice in Nova Scotia. One option being considered would enable DHAs to sponsor part of the education costs for medical students in return for a commitment to work within the sponsoring district. Work on this initiative is still ongoing.
Develop and implement short term strategies aimed at recruiting and retaining health professionals and, where possible, "repatriating" Nova Scotian health professionals from other provinces, other countries and other careers.	Nova Scotia's Department of Health is partnering with the Nova Scotia Community College and the New Brunswick Community College to train, recruit and retain Medical Laboratory Technologists for the province. The application process for this program began in March 2003; classes start in January 2004. Students will receive a $4000 per year bursary in exchange for agreeing to work in the NS health care system for two years following their graduation. This will be an effective strategy to recruit students to the field of medical laboratory technology and retain new graduates in the province.
Lead an interprovincial collaborative effort aimed at maximizing efficiency and effectiveness of health human resource planning among the four Atlantic provinces.	Based on direction from the Atlantic Deputies of Health and Post Secondary Education, a proposal is being finalized to undertake an Atlantic Health Education and Training Study. The project proposal will be submitted to Human Resources Development Canada (HRDC) for funding. The project will establish an integrated information base to enable informed decision making for Atlantic Health Education Planning. This project recognizes that the Atlantic provinces are highly inter-dependent, sourcing from a common pool of human resources for educating and training our health workforce.

Priority	Departmental Accomplishment
Conduct a comprehensive study of alternative physician payment models examining the strengths and weaknesses of each in terms of recruitment, retention, payment basis, scheduling and other relevant factors.	Alternatives to the traditional fee-for-service approach to physician remuneration are being studied and developed for some specialty medical areas and primary health care. The Department is working with the DHAs, Dalhousie University and the Medical Society of Nova Scotia to ensure effective service delivery and efficient resource allocation through alternative funding arrangements. The Department initiated a collaborative process with the Medical Society of Nova Scotia and the DHAs to develop alternative payment plans for physicians entering into general practitioner/nurse practitioner practice agreement.
Continue with implementation of a comprehensive provincial nursing strategy. Emphasis on continuing and speciality education, orientation, recruitment, cooperative learning experiences and bursary programs will remain and be enhanced, where feasible. New initiatives such as RN re-entry to practice, leadership development for clinical and managerial practice, and review of entry level competencies will be considered.	The Nursing Strategy includes initiatives to support recruitment, retention and renewal of the nursing workforce in Nova Scotia. A continued focus on orientation, continuing and specialty education, enhanced recruitment efforts and appropriate workforce utilization helped address the major challenges for nursing. In March 2003, the Department announced as many as 240 more nurses will be educated in Nova Scotia over the next four years under a new $7 million training plan. This funding was in addition to the $10 million already invested in the provincial nursing over the past two years. The Department announced a re-entry program as a recruitment incentive for experienced nurses who want to get back into the workforce. The province will pay for most of the cost of the re-entry program. Some registered nurses that have not worked regularly in the last five years need the re-entry program to be licensed. Those who receive funding agree to work in Nova Scotia for one year after they finish.

Goal: Develop and implement a strategy to ensure the accountable provision of quality and integrated health services by District Health Authorities (DHAs).

Priority	Departmental Accomplishment
Develop a funding methodology for DHAs which ensures equity and consistency based on intensity of the service delivered and on the burden of illness in the population served.	Scoping work for development of an acute care funding formula was initiated during this year.
Study the current DHA governance and service delivery structure in terms of its efficiency, effectiveness and sustainability for the future. The study will include the identification of "best practices" in similar organizations in other jurisdictions and an assessment of the potential for further sharing of administrative and clinical support services.	Opportunities for cost savings through further service consolidation in areas such as laboratory and other diagnostic services were identified and evaluated through the DHA business planning process in 2002-03.
Continue the health services planning process by initiating Phase 3[2] planning for primary care, ambulatory care and emergency services.	A Steering Committee was selected for this third phase of health service planning in Nova Scotia. Phase III extends the methods and findings of Phase I and II to primary health care and emergency services. The process builds on the work of the Advisory Committee on Primary Health Care Renewal, drawing from the work of its task teams. Accordingly, the plan will: - Anticipate the future alignment and integration of primary health care at the DHA level; - Support the development, suitability and sustainability of primary health care and emergency services across Nova Scotia; - Facilitate better matching of health system resources to community and individual requirements; and - Establish an ongoing process by which primary health care and emergency services can be planned and coordinated on an ongoing basis. A report on Phase III is expected in 2004.

[2] Phase 1 (hospital/acute care services) was completed in February 2001.
Phase 2 (continuing care services) was completed in 2002.
Phase 3 (primary care, ambulatory care and emergency services) commenced in 2002.

Priority	Departmental Accomplishment
Provide leadership to DHAs to establish a review of clinical pharmacy practices to identify and eliminate any unnecessary duplication and improve drug utilization practices.	The Department explored ways to communicate new clinical drug information with health care partners.
Work with Community Health Boards (CHBs) and DHAs to clarify and further develop their respective roles and functions to better reflect those anticipated in the *Health Authorities Act*.	A team of DOH and DHA staff undertook an analysis of the *Health Authorities Act*. A number of work teams, which included CHB and DHA members and staff, developed recommendations to bring consistency of role and responsibilities for CHBs, while allowing for local implementation. A series of consultations with the DHAs and CHBs were held to gather feedback on the recommendations over the early summer in 2002. Recommendations aimed at improving DHA - CHB communication and joint planning include a template for by-laws for CHBs, an accountability framework for the CHB - DHA relationship, minimum resource supports for CHBs from the DHAs and a broad framework for the CHB's Community Health Plan. The final recommendations began to be implemented in the fall of 2002 by the DHAs and CHBs.
Develop a policy framework and consistent provincial approach to revenue generation by DHAs in connection with their provision of non-insured services.	As part of their annual business planning process, DHAs are encouraged to seek and maximize revenue potential from non-clinical service delivery areas such as parking lots and office rentals.
Continue to expand the Province's capacity for renal dialysis to cope with the growing demand for this critical service.	Chronic kidney disease has reached epidemic proportions in most western countries with dialysis growth rates at 8-10% per year. In response to the growing demand for dialysis in Nova Scotia, the Department funded the Cape Breton District Health Authority in the establishment of a Dialysis Unit at Northside General Hospital which opened in May 2002.
Improve access to orthopedic services in northern Nova Scotia through support for an expanded orthopedic program at the Pictou County DHA.	The Pictou County District Health Authority recruited two orthopedic surgeons. The program was re-established at the Aberdeen Hospital in New Glasgow. In addition to serving residents of the Pictou County District Health Authority, the program offers access to residents in the neighbouring districts of Colchester East Hants, Cumberland and Guysborough-Antigonish-Strait.
Increase DHA operational funding by 10% and allocate it across the DHAs on the basis of current needs and demonstrated efficiencies.	The Department of Health increased operating budgets for DHAs by 10% in the 2002-03 budget, taking into account the changing service delivery methods and population needs. The $22.5 million increase reflects the priorities of government and the priorities of Nova Scotians. It was in addition to $65 million already set aside to cover wage settlements negotiated last year for nurses and other health care workers.

Priority	Departmental Accomplishment
Develop an accountability framework for DHAs which meets the requirements of the *Health Authorities Act* and which is focused on service quality, resource utilization management, standards development, monitoring processes, financial accountability and outcomes.	The Department continued to improve on its financial accountability processes and reporting, both for our third party providers and for programs managed directly by the Department. The Department's MIS reporting database on District Health Authority (DHA) expenditure was the most complete and accurate to date. Financial and statistical data from DHAs meet national reporting standards and allow for proper DHA to DHA comparisons. The Department began the development and distribution of routine financial indicators and has begun the integration of the use of the MIS database in business planning and budget analysis. 2002-2003 marks the first complete year the Department received completed financial and service reporting from the Home Care and In-Home Support providers. This information is used for budget management purposes. The Department also continues to improve the integration between the business planning and budget development processes. There have also been improvements in our capital project approval and monitoring process.

Goal: Design and implement a primary health care system that meets the needs of Nova Scotians.

Priority	Departmental Accomplishment
Develop and implement a community-based primary health care system for Nova Scotia through the work of a broad based advisory committee and task teams working on such things as provider roles, funding, linkages, governance, etc.	The Advisory Committee on Primary Health Care Renewal included representatives from several health sector stakeholder groups as well as the nine district health authorities. The committee's recommendations focused on health promotion, a greater role for communities in defining needs, a team approach to health care delivery, and effective use of technology as key steps to increasing access to health care services for Nova Scotians. The final report, written during 2002-03, was tabled in June 2003. The Advisory Committee's report is an important source for the Health Services Planning (Phase III) Steering Committee's focus on primary health care, ambulatory care and emergency services planning.
Continue funding and supporting the four primary care demonstration sites in Springhill, Pictou, Caledonia and north end Halifax.	The four nurse practitioners hired in these locations continue to serve their areas and their patients. This community-based primary health care approach is a new way to fund, deliver and manage primary health care using collaborative practice between nurse practitioners and physicians.
Determine the effectiveness and efficiency of a primary health care model for rural and remote communities. Supported by an off-site physician, Long and Brier Islands will pilot a collaborative and community-based approach involving an on-site nurse practitioner and paramedic providing primary care.	In July 2002, the Department of Health announced a nurse practitioner for Long and Brier Islands. The nurse practitioner began work in October with a physician from Digby Neck and with the paramedics. This role is part of a three-year pilot project to help expand primary care services for the 1200 people living on the islands off Digby Neck. This approach is consistent with the Department's health services planning initiative and nursing strategy.
Recruit nurse practitioners to work in primary health care settings in Nova Scotia.	In October 2002, the Department announced eight new nurse practitioners for the province in the communities of Annapolis Royal, Wolfville, Hants North, Advocate Harbour, New Glasgow, the Strait-Richmond area, Inverness and Musquodoboit Valley. Nurse practitioners work with family physi ans and are able to diagnose and treat certain illnesses, order certain tests, x-rays and ultrasounds and prescribe some medications. These new positions are in addition to existing nurse practitioners in Pictou, Caledonia, Springhill, Halifax and Long and Brier Islands.

Goal: Implement a management strategy to address capital issues as related to information, equipment and facilities.

Priority	Departmental Accomplishment
Continue implementation of the Hospital Information System (hIS) project to satisfy the need for timely and relevant clinical and management information for evidence-based decision-making.	A comprehensive hospital information system will make the health records of Nova Scotians available wherever they access hospital-based care in the province. The Nova Scotia Hospital Information System (NShIS) implements clinical information systems across the province to enable health care providers to access the information they need to provide quality health care. The system was implemented in DHAs 7 and 8 with expansion to District 1 to 6 expected to begin in April 2004. Upon completion, the system will be installed in 34 hospitals in District 1 to 8.
With funding participation from Health Canada, continue support of Health Infostructure Atlantic (HIA) in its development of information systems to support Single Entry Access (SEA)/case management and expanded tele-radiology functions.	In fall 2002, Nova Scotia became the first province in Canada to implement the RAI-HC (Resident Assessment Instrument - Home Care) assessment tool province-wide and the first province to augment this tool with an automated intake function and managed waitlist for long term care facilities. Also, Nova Scotia has implemented an automated service plan. This integrated software is named SEAscape. Late fall 2002 marked the start of the provincial Tele-i4/PACS network start-up. Nova Scotia has taken a leadership position in the country by implementing a system that facilitates the sharing of diagnostic images among radiologists across the province. Installed in all regional hospitals, images are acquired, stored in a central archive and, if required, can be accessed on demand by any radiologist in the province for consultation and reporting. The initial modality is CT with plans to expand to all diagnostic imaging modalities over the next few years. HIA continues to provide leadership for Atlantic Canada Information Management/Technology collaboration. Opportunities are being evaluated in areas such as pharmacies, telehealth, and common approaches to funding opportunities with Canada Health Infoway.
Develop and implement a process for facility and equipment infrastructure management across the acute care and long term care sectors.	A template to collect basic facility data has been developed. Collection of base data is now underway. This will provide a foundation for later data collection on targeted issues. The Department continues to manage the infrastructure requirements of the two sectors.
Develop and implement a plan for infrastructure assessment, repair and management in long term care facilities across Nova Scotia.	Best practice models for collection and analysis of building condition data have been researched and a system selected. Collection of data and analysis are planned. This work will complement existing and developing capital infrastructure planning. Independent condition assessments were completed on two facilities.

Goal: Develop policies and standards that promote health and prevent illness based on evidence, best practice and intersectoral collaboration.

Priority	Departmental Accomplishment
Develop and implement a broad-based and comprehensive approach to disaster planning which encompasses bioterrorism, pandemic flu, and surveillance and alert strategies.	The Department of Health developed a planning framework for an effective and escalating response to threats such as SARS, West Nile Virus, terrorist associated chemical, radio-nuclear or biological events, pandemic influenza and the possibility of emerging infectious diseases. This framework includes surveillance, communication, public health measures, health services, and emergency preparedness and response. Implementation of this work will continue in 2003-04 in partnership with the federal government and other provincial/territorial jurisdictions.
Develop and implement an intersectoral approach to address service gaps in addiction services for women and youth.	The Department of Health invested $1.8 million to enhance community-based addiction services. As part of that strategy, the DHAs hired 26 new addiction workers. New staff work with schools, youth and women's groups, community groups and other health-care providers to increase prevention efforts and reduce the harm caused by addictions. They also deliver more treatment programs, such as mobile clinics, group counseling sessions and day treatment programs that are tailored to the needs of women and youth.
Develop an enhanced home visiting component to the existing Early Childhood Development project in cooperation with the Department of Community Services and with funding support from the federal government.	Healthy Beginnings, announced in November 2002, is a provincial program designed to make the early days and years with a new baby easier. It allows public health nurses and specially trained home visitors to offer ongoing home visits for up to three years for families needing more support. The home visits can provide everything from parenting and breastfeeding support to helping family access other resources in their community, like childcare, family resource centres or programs for children with special needs. Under the guidance of the Provincial Healthy Beginnings Provincial Steering Committee, the following accomplishments were achieved: - development of the provincial program framework, standards and targets; - budget allocation disbursement to the Public Health Services, DHAs for program planning and implementation; - development of DHA financial reporting system to DOH for Early Childhood Development/Healthy Beginnings funds; - development of a provincial database to support local monitoring of Healthy Beginnings implementation; - allocation of funding for professional development and training to support public health services staff conducting universal postpartum screening and in-depth family assessment; - formation of local implementation teams (led by Public Health Services); and - initiation of Public Health services additional staff recruitment to support full implementation of this initiative within budget. Healthy Beginnings is funded through the $2.2 billion federal Early Childhood Development Fund announced in 2001. Other work receiving support from the Early Childhood Development Fund includes quality childcare, parent education and support, and early childhood systems development.

Priority	Departmental Accomplishment
Reduce smoking rates in Nova Scotia and the burden of illness from tobacco-related illness through tobacco pricing and taxation, smoke-free policies and legislation, treatment and smoking cessation programs, community-based programming, youth smoking prevention approaches, media and public awareness, monitoring and evaluation.	The province's Comprehensive Tobacco Strategy addresses key elements critical to the success of tobacco control efforts. The strategy is supported by a $1.5 million annual investment. Significant progress was made in strategy implementation in 2002-03. Tobacco price increases occurred in April 2002 and January 2003. The Smoke-Free Places Act came into effect and significantly restricts smoking in most workplaces and public places throughout the province. Funding has been provided to District Health Authorities to support the hiring of co-ordinators to run community-based smoking-prevention programs and addictions staff to enhance nicotine dependency treatment services. A province-wide tobacco public awareness campaign has been launched and includes new television and print advertisements. Enforcement of the Tobacco Access Act (restricting sales to minors) is ongoing. Measures to track the effectiveness of these efforts include the proportion of the non-smoking population regularly exposed to environmental smoke in public spaces and work places and the percentage of youth who smoke (for more information, please refer to the section on Outcome Measures).

Goal: Develop and implement a plan for the care of mentally ill adults, youth and children.

Priority	Departmental Accomplishment
Enhance the mental health system across the lifespan by developing strategies for mental health consumer involvement, reducing the stigma of mental illness and increasing public awareness. Core program standards and an evaluation framework will also be developed.	In February 2003, the Department of Health released its strategic direction for mental health services and standards, and Nova Scotia is the first province in Canada to have standards to support this direction. The standards address appropriate numbers and qualifications for staff, timely access to emergency care and treatment, and follow-up with patients after hospital discharge. The standards and direction were developed by more than 200 Nova Scotians including mental health professionals, advocacy groups, people who use mental health services, and members of their families. The mental health standards will assist the DHAs and the IWK with a self-assessment process that will facilitate the development of mental health services planning. Meeting mental health standards across the province is expected to take 5 to 10 years. Work began on Consumer Initiative Grants to increase consumer involvement in planning, delivering and evaluating mental health services. The department invited proposals from community groups in September 2002 and received 23 funding applications. Six projects, totaling $150,000, were selected: Public education on eating disorders - Eating Disorders Community Support, Yarmouth A mental health advocacy skills program - Strengthen Our Sustainability, Inverness Postpartum depression support - Parent Resource Centre, Dartmouth Schizophrenia education kit - Schizophrenia Society of Nova Scotia, Dartmouth Parents' resource library - Parents' Place, Yarmouth Advocacy and leadership skills program - Depression, Manic Depression and Family Support/Self-Help Society of Nova Scotia, Digby
Develop a framework for delivering mental health services for children and youth in residential treatment settings.	Under the framework of the new strategic direction for mental health, two new mental health community-based treatment teams were developed in 2002-03. The teams were planned for the Cape Breton DHA and the IWK Health Centre, to serve children and youth who require an intensive level of care. Addressing a longstanding gap in mental health services, they provide a level of service that falls between outpatient treatment and inpatient services. Tele-health technology will be used to promote consultation between the community-based treatment teams. Work also began on a new 12-bed residential rehabilitation treatment centre which was scheduled to open later in 2003. It will provide professional care and security that previously could be provided only outside of Nova Scotia for most children. This centre will be available to those who require medium to longer-term care.

Priority	Departmental Accomplishment
Develop a strategy for an intersectoral response to the changes in the federal *Youth Justice (Young Offenders) Act.*	The Youth Justice Act came into effect April 1, 2003. The Departments of Health and Justice are developing: - single-entry access for Court-ordered assessments; -a clinical mental health team, Nova Scotia Youth Centre for Intensive Rehabilitative Custody and Supervision Program; -telehealth capabilities to connect all mental health services at the DHA/IWK for case conferencing and community based follow-up; -training programs for both Mental Health and Justice personnel; and -a bursary for an adolescent psychiatrist to receive advanced training in youth forensic.

Goal: Identify strategies which facilitate improved disease management[3] across the continuum of health care and service.

Priority	Departmental Accomplishment
Re-orient the ICONS[4] program to integrate its functions as a component of a sustainable and comprehensive provincial cardiovascular program.	Building on the success of ICONS, DOH is working with a broad range of stakeholders from across the province to develop a coordinated approach to the planning and delivery of cardiac services across the province.
Develop and implement a framework for provincial health programs which promotes the disease management principle of coordinating resources for patients with chronic conditions across the health care system and the life-cycle of the illness.	The department undertook comprehensive approaches to planning health system-wide responses to osteoporosis, stroke and heart disease. For osteoporosis, health system stakeholders were involved in action planning for the recommendations in the Report of the Provincial Osteoporosis Committee completed in 2002. Two new DEXA (Dual Energy X-ray Absorptiometry; commonly known as bone densitometry) machines will becomes fully operational in 2003-04; one in Sydney and one in Yarmouth. For heart disease, building on the success of ICONS (Improving Cardiovascular Outcomes in Nova Scotia), the Department began work with a broad range of stakeholders from across the province to develop a coordinated approach to the planning and delivery of cardiac care across the province. The department worked collaboratively with the DHAs to examine the direction and process for implementing a provincial approach to stroke care. This approach will be based on the recommendations of the *Reorganizing Stroke Care in Nova Scotia: Report of the NS Integrated Stroke Strategy Committee*, sponsored by the Heart & Stroke Foundation of Nova Scotia.
Develop and implement a coordinated, realistic and comprehensive strategy for blood borne pathogens (HIV/AIDS, hepatitis B and hepatitis C) which addresses the needs of clients from prevention to palliative care.	Understanding that hepatitis B, hepatitis C, Human Immunodeficiency Virus (HIV) and other blood borne pathogens (BBPs) are preventable, the Department of Health began the Prevention of Blood Borne Pathogens Project in July 2002. The Project facilitates coordination and integration of a system of prevention and social support services to address the prevention needs and contribute to the overall goal of decreased incidence and prevalence of BBPs. Stakeholders provided support for the approach represented by the model. Four working groups were established to develop standards in four priority areas: prevention and wellness promotion, opiate replacement therapy (methadone), testing (including anonymous HIV testing) and needle exchange.

[3] Disease management aims to coordinate resources for patients with chronic conditions across the health system and the life-cycle of the illness. Published research support the effectiveness of disease management approaches for cardiovascular and other diseases in achieving the best outcomes for the most people at the lowest cost.

[4] ICONS stands for Improving Cardiovascular Outcomes in Nova Scotia. ICONS was a wide-ranging 5-year disease management research project funded by a major pharmaceutical company and administered by the QEII Hospital. It achieved positive results in improving the consistency and quality of cardiovascular care in Nova Scotia hospitals and in improving outcomes for certain groups of patients.

Priority	Departmental Accomplishment
Develop, in partnership with a wide range of stakeholders, a chronic disease prevention strategy with integrates the Nova Scotia Tobacco Strategy and related national initiatives with evolving strategies such as the Physical Activity in Children and Youth (PACY)[5] strategy.	Understanding that chronic diseases are the leading causes of death in Nova Scotia, the Department of Health worked on developing a provincial Chronic Disease Prevention Strategy through the Unit for Population Health and Chronic Disease Prevention at Dalhousie. The Department maintained active representation on each of the eight working groups to facilitate integration with existing and evolving strategies/opportunities at the provincial and national levels. In addition, the Department provided management and strategic support for the overall development of strategy. Recommendations from the report are expected in fall 2003. Nine "active school community" pilot projects were launched. These projects explore ways that teachers, students, parents, administrators and community leaders can work together to encourage young people to be more active. In-school and after-school programs, family and community activities, and ways to increase time for physical education within the school day are some of the issues being explored. A new Office of Health Promotion was announced in December 2002, and commenced operations in early 2003.
Continue implementation of an Academic Detailing Service (ADS) aimed at improving physician prescribing practices, drug utilization management and clinical effectiveness.	In an initiative funded by the Department of Health and managed by Dalhousie Continuing Medical Education (CME), Nova Scotia is the first province in Canada to undertake a province-wide academic detailing program. In this form of CME, trained health care professionals visit physicians individually to provide objective, evidence-based CME on a particular topic in brief (15-20 minute) educational sessions. Before sessions that involve drug therapy, each physician may receive, from Pharmacare, a confidential personal prescribing profile for the class of drug to be discussed. While the academic detailer will not have this profile, the physician may choose to discuss it with the detailer as part of the session. ADS has completed visits for three topics. Physician evaluations of this service continue to be positive.

[5] The PACY Strategy, now known as Active Kids/Healthy Kids, is coordinated by the Sport and Recreation Commission, now part of the Office of Health Promotion.

District Health Authority Accomplishments	
DHA #1 South Shore	The South Shore DHA completed its Clinical Services Plan which resulted in many positive initiatives including: - the establishment of a Permanent Pacemaker Insertion Program at South Shore Regional Hospital - the successful recruitment of a full-time pediatrician - the purchase of telehealth equipment for North Queens Health Centre - funding announced for the Women's and Children's Health Centre
DHA #2 South West Nova	In July 2002, the Department of Health announced a nurse practitioner for Long and Brier Islands. The nurse practitioner, who began work in October, works with a physician from Digby Neck and with the paramedics. This role is part of a three-year pilot project to help expand primary care services for the 1200 people living on the islands off Digby Neck. In January 2003, a prenatal clinic opened at Yarmouth Regional Hospital. Six doctors serve the clinic and pregnant women without a family doctor can refer themselves to clinic.
DHA#3 Annapolis Valley	A new Addiction Services Centre was opened at Soldiers' Memorial Hospital. The Detox programs and 28-day programs offered in Kentville were moved to this new location in Middleton.
DHA#4 Colchester East Hants	In December 2002, Colchester East Hants Health Authority and its partners, Cumberland Health Authority and Pictou County Health Authority launched a new mobile breast screening program that travels to communities throughout Colchester East Hants as well as Pictou and Cumberland counties. In Fall 2002, a new Addiction Services office opened in Enfield, as part of a $1.8 million DOH investment aimed at improving services for those with addictions in rural areas.
DHA#5 Cumberland	In October 2002, the Cumberland Regional Health Care Centre opened, replacing the Highland View Regional Hospital. The 65-bed facility offers a wide range of programs including a laboratory, diagnostic imaging department complete with CT Scan, pharmacy, and respiratory and occupational therapy departments. Advocate Harbour, a small community, opened a collaborative practice between a physician and nurse practitioner.
DHA#6 Pictou County	In September 2002, the Pictou DHA established an Ear, Nose and Throat (ENT) clinic at the Aberdeen Hospital. In February 2003, it also established a new family practice clinic at Sutherland Harris Memorial Hospital.

District Health Authority Accomplishments	
DHA#7 Guysborough Antigonish Strait	In February 2003, GASHA was the first district to implement the NShIS software and system. It is a comprehensive hospital information system that will make the health records of Nova Scotians available wherever they access hospital-based care in the province.
DHA#8 Cape Breton	A new bone densitometer opened at the Cape Breton Regional Hospital. This in addition to the two units that operate full time in Halifax and Lunenburg and the one that operates part time in Truro. A Satellite Clinic for Child and Adolescent Mental Health Services opened Neil's Harbour. It provides individual counseling, group and family programs, mental health education, and school outreach services.
DHA#9 Capital	Capital Health opened a fourth cardiac catheterization lab and was able to increase the number of cardiovascular surgeries and elective cardiac surgeries performed. Capital Health partnered with the Halifax Regional School Board to present "Be Active for Fun. Be Active for Life", a physical activity challenge for grades Primary to 12.
IWK	The IWK introduced its Intensive Community Based Treatment service for high-need youth in the mental health system. A Cardiac Catheterization/Angiography Suite and an Autism Research Centre both opened in 2002-03. In June 2002, the IWK installed a new MRI unit.

Financial Results 2002 - 2003

(in thousands)

Core Businesses	2002/03 Budget	2002/03 Actual	Variance
DoH Provincial Policy, Planning, and Corporate Services			
* Health System Design * Strategic and Policy Support to the Health Care System * Accountability Support for the Health System			
Total	**31,962**	**31,466**	**(496)**
Funding Support to the Health System			
Total (DHA / PHCCs)	987,023	1,008,768	21,745
Service Delivery Management	961,250	1,000,585	39,335
Total (DoH Services)	**1,948,273**	**2,009,353**	**61,080**
Total	**1,980,235**	**2,040,819**	**60,584**

Variance Explanations:

DOH Provincial Policy, Planning and Corporate Services:
This shows a $500K variance due to vacancies

DHA/PHDCC's:
Due to Year End Deficits - $21.7M

Service Delivery Management:
Medical Payments: Increased fees and utilization - $1.6M
Pharmacare: Increased utilization - $.4M
Other Insured Programs: Increased utilization and co-pay costs - $1.9M
Home Care: Due to vacant positions (Care Coordinators and SEA Positions) and service utilization charges throughout year in Home Support hours decreased - ($5.9M)
Canadian Blood Service: Based on usage of blood fractionation products, based on Nova Scotian's utilization - $2.8M
Long Term Care: One-time capital project A/P reversal, increase in client incomes and vacant beds, late opening Shannex new buildings and allocation of wage settlement funding for 2002/03 - ($4.9M)

Capital Grants: Approximately $45 Million expenditures are Capital Grants and recorded in this account temporarily to be eliminated upon Government consolidation ($30M - Capital Grants - Infrastructure & $15M - Diagnostic & Medical Equipment Fund) - $44.8M
Revenue and Recovery: Higher than anticipated billings specifically from New Brunswick and Ontario - $1.6M

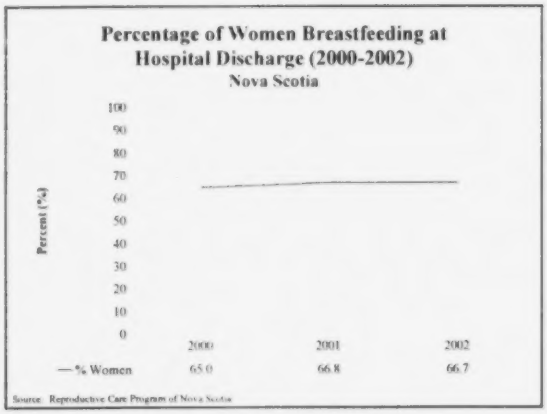
2002 - 2003 Department of Health Outcomes Report

Note:

The following measures provide an overview of important information about health services in Nova Scotia and the health of Nova Scotians. Some of the measures in this report have changed from those used in previous years. New measures have been chosen because they provide better, more consistent information that is compatible with the national approach and allows for cross-country comparisons. Because some federal agencies have deadlines that differ from Nova Scotia's deadlines, some 2002-2003 information was not available for this report.

Percentage of Women Breastfeeding at Hospital Discharge

One of the Department's core business areas is Population Health and Primary Health Care. A desired outcome that falls within the scope of this business area is Healthy Babies, Children and Families. One measure of this outcome is the percentage of women breastfeeding at hospital discharge.



What Does the Measure Tell Us?

This measure is the number of women known to be breastfeeding at hospital discharge as a percentage of the number of women whose breastfeeding status (yes or no) is known. Breastfeeding has been identified as the optimal method of feeding worldwide because of the proven health benefits for infants and mothers.

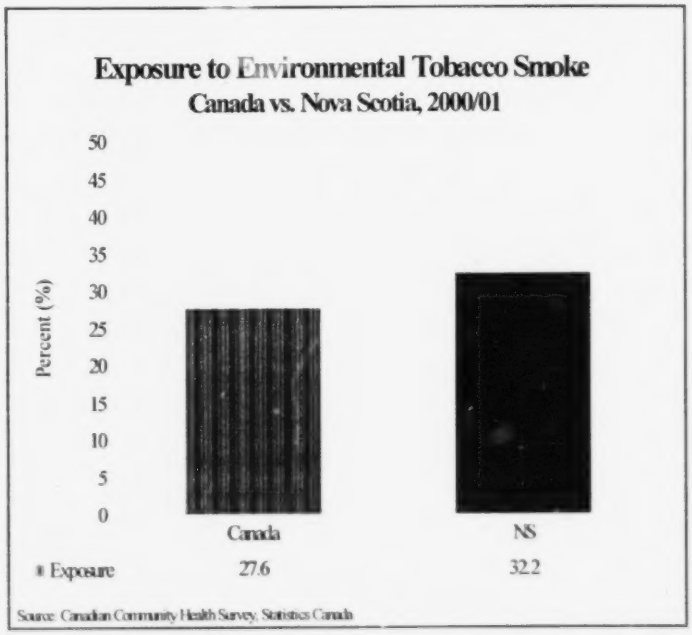
Where Are We Now?

Data over the last three years shows a slow increase in women breastfeeding at the time of hospital discharge.

Where Do We Want to Be in the Future?

By 2004-05, the Nova Scotia government aims to increase the percentage of the women breastfeeding at hospital discharge to 73%. Strategies to achieve this target include continuing to promote, support and protect breastfeeding through extensive local Public Health Services; continuing to work on provincial and District Health Authority breastfeeding and Baby-Friendly Initiative policy development, and developing breastfeeding education standards for professionals.

Proportion of Non-smoking Population Regularly Exposed to Environmental Tobacco Smoke in the Home, Public Spaces, and Work Places



One of the Department's core business areas is Population Health and Primary Health Care. A desired outcome that falls within the scope of this business area is Healthy Babies, Children and Families. Certain environmental conditions are known to be harmful to health. One of these is second-hand tobacco smoke.

What Does the Measure Tell Us?

This measure describes how many nonsmoking Nova Scotians (aged 12 years and over) were exposed to second-hand smoke on most days during the previous month. Living or working in a smoke-filled environment can lead to serious health problems, such as lung cancer and heart disease. At least 200 non-smoking Nova Scotians die every year from exposure to second-hand smoke. Many more suffer from bronchitis, ear infections, pneumonia, heart problems, and other diseases. Asthma, allergies, and environmental illnesses are all aggravated by tobacco. Reducing exposure to tobacco smoke is key to preventing these illnesses.

Where Are We Now?

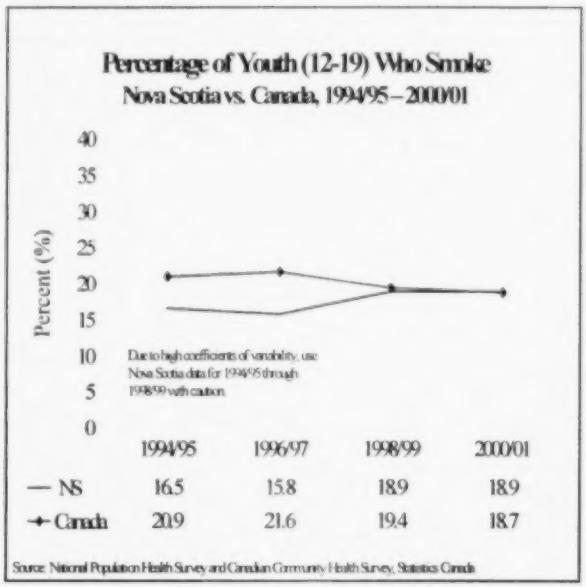
In 2000, approximately 32% of Nova Scotian non-smokers report being regularly exposed to second-hand tobacco smoke. This contrasts with approximately 28% of Canadians in general who report exposure to second-hand smoke. This measure has not been updated since last year's Accountability Report. It is collected every two years and new information will be available in next year's report.

Where Do We Want to Be in the Future?

Nova Scotia is implementing a province-wide Comprehensive Tobacco Strategy. The strategy addresses seven key components: taxation, smoke-free places legislation, treatment/cessation, community-based programs, youth prevention, media awareness, and monitoring and evaluation. Through this comprehensive approach, by 2004-2005 we hope to have decreased the second-hand tobacco smoke exposure rate to the Canadian average or less.

Percentage of Youth Who Smoke

One of the Department of Health's core business areas is Population Health and Primary Health Care. Smoking is the number one cause of preventable death and disability. High rates of smoking translate into high rates of chronic disease such as lung cancer, heart and respiratory disease. Reducing youth smoking is key to the prevention of smoking related illness and to the promotion of healthy populations.



What Does the Measure Tell Us?

This measure describes the percentage of youth (aged 12 to 19 years) who smoke in Nova Scotia and Canada. Habits adopted during the teen years tend to be maintained well into adult life. Therefore, this measure informs us about smoking among young people as well as the number of adults who may be smokers in the future. Preventing or limiting smoking among young people has important long term benefits such as reduced smoking among adults and the prevention of serious illness.

Where Are We Now?

In 2001, 18.9% of Nova Scotia's youth (aged 12 to 19 years) smoked, compared to 16.5% in 1994/95. In Canada, the smoking rate in youth declined from 20.9% to 18.7%. These data tell us that youth smoking in Nova Scotia has increased while Canadian youth smoking has decreased. Youth smoking rates differ dependent on what data source is used primarily because of the age range and methodology applied. The youth smoking data used in this report are from a database that was agreed upon by the federal/provincial/territorial Ministers of Health in order to be consistent with the report that all provinces will produce, but has not been updated since last year's Accountability Report. It is collected every two years and new information will be available in next year's report.

However, more recent data are available from the Canadian Tobacco Utilization Monitoring Survey (CTUMS), which is done annually. According to CTUMS, youth smoking rates for NS are 25% for 2000, 27% for 2001 and 20% for 2002.

Where Do We Want to Be in the Future?

Our aim is to decrease the percentage of youth who smoke. Strategies to achieve this target include continued implementation of all components of the Comprehensive Tobacco Strategy.

Percentage Reporting Body Mass Index in Excess of the Healthy Range

One of the Department's core business areas is Population Health and Primary Health Care. A desired outcome within this area is decreased overweight and obesity.

A normal body weight (for height) is associated with a reduced risk of health problems. Overweight and obesity are associated with increased risk of health problems and conditions such as high blood pressure, diabetes, gall bladder disease, and pregnancy complications. Body weight is influenced by genetic, gender, age, and lifestyle factors such as poor eating habits and inadequate physical activity. Canada's Guidelines to Healthy Eating (1992) recommend that Canadians "achieve and maintain a healthy body weight by enjoying regular physical activity and healthy eating". Nova Scotians need to be supported through education and skills, policy, and enhanced community capacity to adopt and maintain healthy body weights, healthy eating and physical activity behaviours.

What Does the Measure Tell Us?

The Body Mass Index (BMI) is a valid measurement of weight in relation to health for healthy adults aged 18-65 years. This is a common method for calculating if an individual's weight is in a normal range based on their body weight and height. BMI is not recommended for use as the sole measurement of either body composition or level of physical fitness. According to new Health Canada weight classification guidelines (2003), a BMI between 20 and 25 is considered within a normal weight range. This measure has not been updated since last year's Accountability Report. It is collected every two years and new information will be available in next year's report.

Where Are We Now?

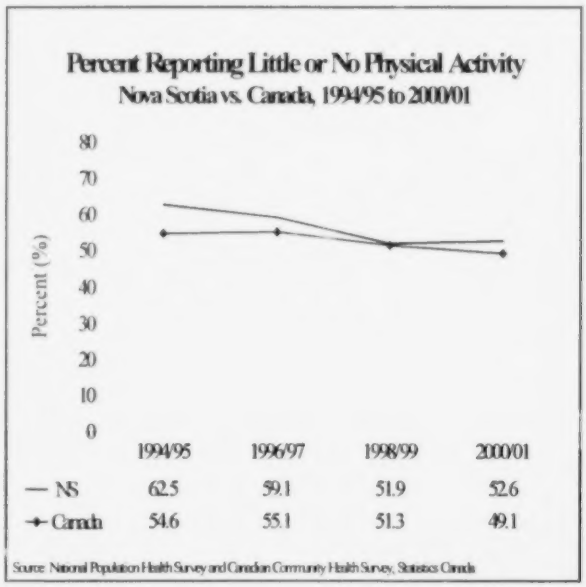
Since 1993, the percentage of Nova Scotians who have a BMI above 25 is greater than the Canadian population in general. In 2000-01, 55.2% of Nova Scotians reported a BMI above 25, as compared to 47.4% of the Canadian population. The data in this report differ from those described in the 2002-03 Business Plan because the data sources are different. That is, the 2002-03 Business Plan used the Canadian Standard for reporting BMI whereas data in this report used the International Standard. This change represents consistency with provincial reporting as agreed to across Canada.

Where Do We Want to Be in the Future?

By 2004-05, with partners at multiple levels and in multiple sectors, the Nova Scotia government aims to decrease to 52% the number of Nova Scotians whose body weight increases their risk for health problems. Toward this end, the Department of Health has continued to develop and strengthen strategic linkages in the community and other sectors. In addition, the Department will collaborate with the Nova Scotia Alliance for Healthy Eating and local public health services to promote behaviours, capacity, and policies that support and protect healthy eating and physical activity.

Physical Inactivity: Percentage of Nova Scotians (12 Years and Older) Who Are Considered Inactive

One of the Department of Health's core business areas is Population Health and Primary Health Care. A desired outcome within this area is an increase in health-related behaviour. Physical inactivity is an important indicator of unhealthy behaviour. Studies show that inactivity is a major risk factor for heart disease and depression and that regular physical activity can provide important health benefits.



What Does the Measure Tell Us?
Physical inactivity is measured by calculating the proportion of the population aged 12 years and older who report being physically active less than once per week or never. The province's goal is to increase physical activity among Nova Scotians.

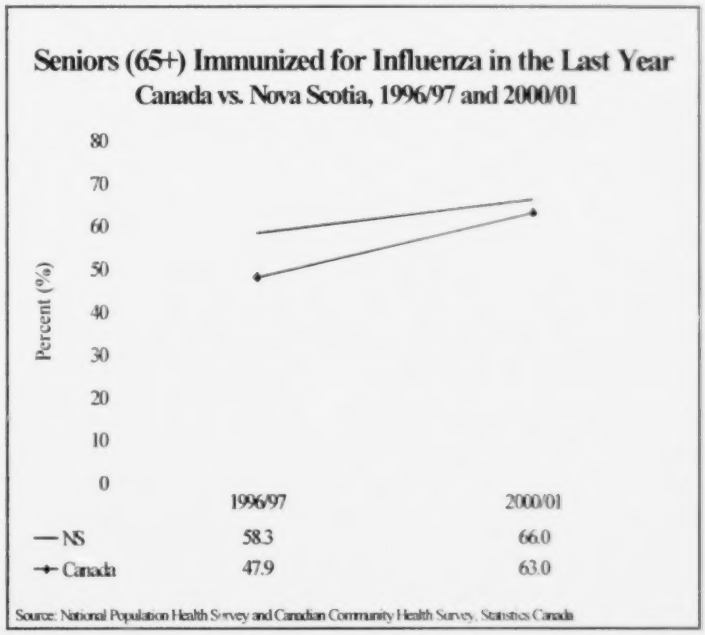
Where Are We Now?
In 2000-01, 52.6% of Nova Scotians reported being physically active less than once per week or never, as compared with 49.1% of Canadians. This measure has not been updated since last year's Accountability Report. It is collected every two years and new information will be available in next year's report.

Where Do We Want to Be in the Future?
Maintaining regular physical activity is associated with many benefits, including improved cardiovascular and mental health. The province's goal is to increase physical activity through joint initiatives such as the Active Kids/Healthy Kids Strategy, the Chronic Disease-prevention Strategy, and curriculum revisions to increase physical activity in schools. The Department of Health participates in these initiatives.

In February 2003, the federal Minister of Health and the provincial/territorial Ministers responsible for Sport and Recreation announced their intention to increase by 10% the number of people in each province who are physically active enough to achieve health benefits by 2010. For Nova Scotia, this means this measure will change from Physical Inactivity to Physical Activity. With that change, the measure will be 47.4% of Nova Scotians are active (instead of 52.6% inactive) and the goal will be to increase that number to 57.4% by 2010.

Percentage of Nova Scotians (65 years and older) Who Received a Flu Shot in the Past Year

One of the Department of Health's core business areas is Population Health and Primary Health Care. A desired result of work within this area is the reduction of diseases which can be prevented by vaccine. Vaccination coverage is important in promoting and maintaining public health and preventing the spread of infectious disease.



What Does the Measure Tell Us?

Vaccination coverage is measured by calculating the percentage of people (aged 65 years and older) who reported having their last flu shot during the past year. By increasing the number of people who receive flu shots, we can decrease the burden of illness on vulnerable populations - such as the elderly - and reduce the strain on the health system at the same time.

Where Are We Now?

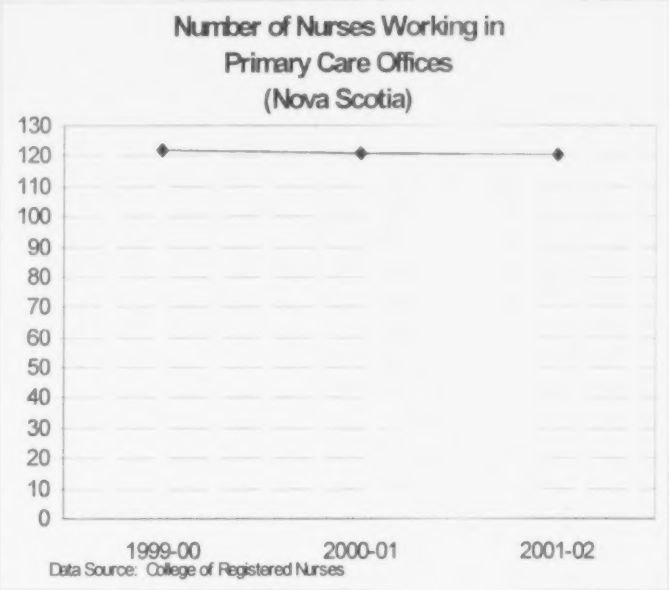
During 2000-01, 66%of the Nova Scotian population over 65 years of age reported having had a flu shot in the last year, as compared with 63% of all Canadians 65 or older. This shows an improvement since 1996-97 when 58.3% of Nova Scotians and 47.9% of Canadians in general reported receiving flu shots. Overall, Nova Scotia compares very favourably with other provinces. Decreases in the hospitalization of people with influenza and pneumonia may reflect the success of the immunization program and aggressive public awareness campaigns. The data in this report (66%) differ from those described in the 2002-03 Business Plan (62.0%) because the data sources are different. That is, the 2002-03 Business Plan used data from the Nova Scotia Department of Health (surveillance system) whereas data in this report come from the National Population Health Survey and Canadian Community Health Survey. This change represents consistency with provincial reporting as agreed to across Canada.It is collected every two years and has not been updated for this Accountability Report; new information will be available in next year's report.

Where Do We Want to Be in the Future?

Immunization against the flu is an important public health intervention. By 2004-05, the province aims to increase to 80% the percentage of the population aged 65 years and older who receive influenza vaccinations.

Number of Nurses Working in Primary Care Offices

One of the Department of Health's core business areas is Insured Health Programs which includes the services of many health care professionals. A desired outcome in this area is ensuring the appropriate number and distribution of health care providers. One way to assess the supply and distribution of health care providers is by calculating the number of nurses working in primary care offices.



What Does the Measure Tell Us?

The number of registered nurses working in primary care offices is a measure of the potential professional nursing capacity available in primary health care organizations across the province.

Where Are We Now?

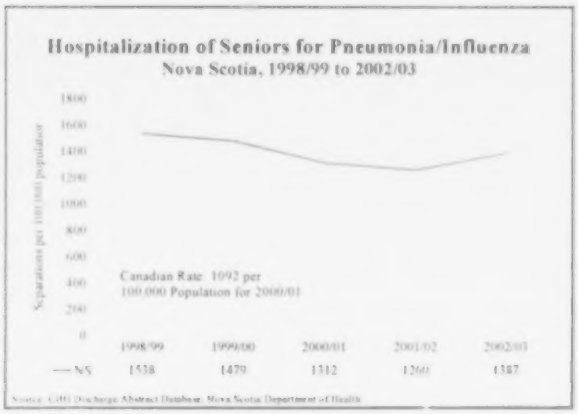
In 2001/02, there were 120 nurses working in primary care offices. This is consistent with the previous two years' data. This figure is based on the number of nurses who indicate on nursing registration forms for the College of Registered Nurses of Nova Scotia that their place of employment as a physician's office.

Where Do We Want to Be in the Future?

A target for 2004-05 has not been set. Strategies to promote the number of nurses working in primary care offices include planning for the development of a renewed community-based health care system for Nova Scotia and support for the nurse practitioner education program.

Hospitalization of People Aged 65 Years or Older for Pneumonia and Influenza

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is the appropriate use of all health care settings. One way to measure the appropriate use of health care settings is by calculating the number of hospitalizations for pneumonia and influenza among people aged 65 years or older. Many cases of influenza and pneumonia can be prevented through immunization.



What Does the Measure Tell Us?

Calculating the number of people aged 65 years or older who are hospitalized for pneumonia and influenza can help us to assess the success of programs to prevent illness altogether or contain its severity and permit management outside of hospital.

Where Are We Now?

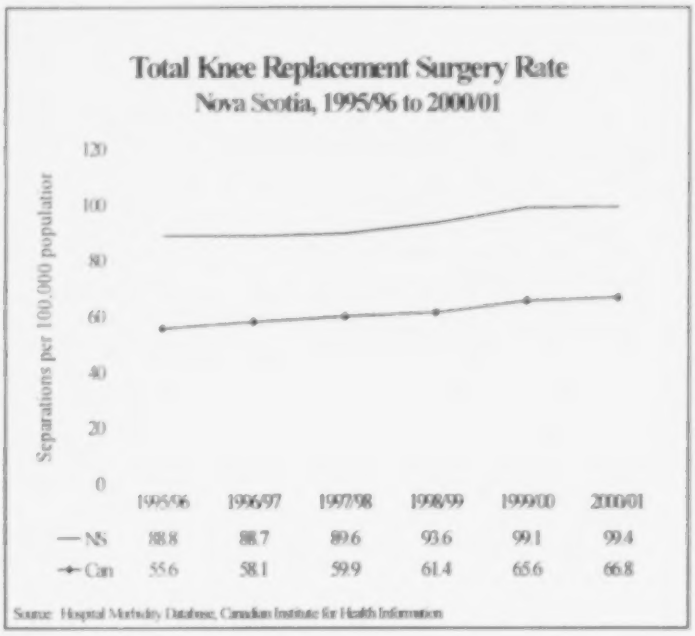
During the year 2002-2003, 1387 people per 100,000 population aged 65 years or older were hospitalized for pneumonia and influenza. This shows a decrease since 1998-1999 when 1,538 people were hospitalized, however, it is a slight increase over the previous year.

Where Do We Want to Be in the Future?

The Department's target is to reduce the number of hospitalizations for pneumonia and influenza to levels consistent with or below the Canadian average. Towards this end, the Department of Health will monitor opportunities to use outpatient services whenever appropriate to treat pneumonia and influenza and will continue to work towards increased vaccination coverage of the population aged 65 years or older.

Number of Total Knee Replacement Surgeries

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is ensuring access to quality hospital services. This may be measured by assessing the rate at which various procedures requiring hospital stay are performed. One of these procedures is Total Knee Replacement Surgery.



What Does the Measure Tell Us?

Rates for Total Knee Replacement Surgery are age-standardized measures of the number of knee replacement surgeries performed on inpatients in acute care hospitals per 100,000 population. The number of Total Knee Replacement Surgeries performed reflects access to required services.

Where Are We Now?

Total Knee Replacement Surgery is known to result in considerable improvements in functional status, pain relief, and overall quality of life. Over the past six years, the number of Total Knee Replacement Surgeries in Nova Scotia has increased from 88.8 per 100,000 of the population in 1995-1996 to 99.4 per 100,000 of the population in 2000-01. During the same period, rates of Total Knee Replacement Surgery have increased across Canada from 55.6 per 100,000 of the population in 1995-1996 to 66.8 per 100,000 of the population in 2000-01. This suggests that Nova Scotians have as much access to Total Knee Replacement Surgery as other Canadians.

Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotian Total Knee Replacement Surgery rates at levels better than or consistent with the Canadian average (66.8 per 100,000 in 2000-01).

Number of Total Hip Replacement Surgeries

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is access to quality hospital services which can be measured by assessing the rate at which various procedures requiring hospital stay are performed. One of these measures is the Total Hip Replacement Surgery Rate.

What Does the Measure Tell Us?

Total Hip Replacement Surgery Rates are age-standardized measures of the number of Total Hip Replacement Surgeries performed on inpatients in acute care hospitals per 100,000 population. The number of Total Hip Replacement Surgeries performed reflects access to required health services.

Where Are We Now?

Total Hip Replacement Surgery is known to result in considerable improvement in functional status, pain relief, and other gains in health-related quality of life. Over the past six years, the number of hip replacement surgeries in Nova Scotia decreased from 73.2 per 100,000 of the population in 1995-1996 to 70.9 per 100,000 of the population in 2000-01. During the same period, rates of Total Hip Replacement Surgery have increased across Canada from 56.8 per 100,000 of the population in 1995-1996 to 57.6 per 100,000 of the population in 2000-01. While our rate has decreased over the past six year, the trend still suggests that Nova Scotians have as much access to this procedure as other Canadians.

Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotian Total Hip Replacement Surgery rates at levels better than or consistent with the Canadian average (57.6 in 2000-01).

Percent of People Admitted to Hospital for Conditions or Procedures That Experts Say Often Allow Outpatient Treatment Instead (May Not Require Hospitalization)

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area making the best use of inpatient hospital services. This may be measured by calculating the percentage of people who are admitted to hospital for conditions or procedures that may not require inpatient hospitalization.

What Does the Measure Tell Us?

As medical technologies improve, many conditions and treatments that formerly required a stay in hospital can now be provided as day surgery or outpatient treatments; for example, hernia repairs, tubal ligation and tonsillectomy. The relative numbers of inpatient hospitalizations for these conditions or treatments can serve as one indication of how efficiently services are being delivered. This measure is based on a grouping methodology provided by the Canadian Institute of Health Information. Decreases in this percentage may reflect improvements in the use of inpatient hospital services.

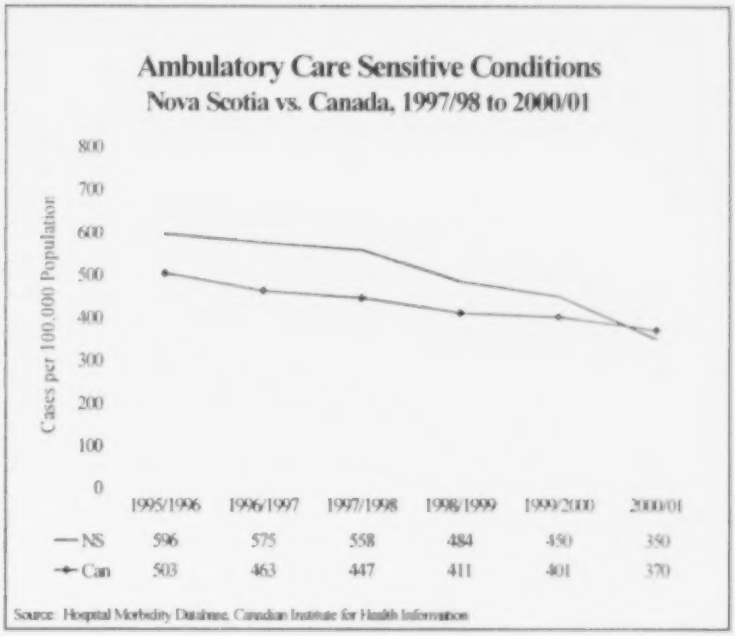
Where Are We Now?

The methodology used to calculate this indicator is being refined by the Canadian Institute of Health Information. No new MNRH data will be available until April 2006.

Where Do We Want to Be in the Future?

Nova Scotia wants to continue to reduce its admission to hospital for treatments that can be provided in an outpatient setting, thereby providing care in the most appropriate setting. The Department of Health will continue to monitor the effective utilization of hospital beds and the use of alternative settings for care in the Nova Scotia health system.

Proportion of People Admitted to Hospital for Conditions Where Appropriate Primary or Ambulatory Care May Prevent or Reduce the Need for Hospitalization (Ambulatory Care Sensitive Conditions)



One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is ensuring the best use of inpatient hospital services. It is also important to ensure that patients have access to adequate primary health care services. One way to assess this is by calculating the number of people admitted to hospital for ambulatory care sensitive conditions, or conditions which are recognized as "manageable" in a primary health care setting.

What Does the Measure Tell Us?

The measure describes the proportion of people admitted to hospital for conditions where appropriate primary health care or ambulatory clinic care may prevent the need for hospitalization. These conditions include chronic conditions such as diabetes, hypertension and asthma, which can often be managed with timely and effective treatment in the community. Calculating hospitalization rates for such conditions can help us to measure adequacy of access to community-based care. Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health, contributes to better overall community health, and saves money because community-based care usually costs less than hospitalization. Tracking hospitalization rates for these conditions over time can provide an indicator of the impact of community and primary health care services.

Where Are We Now?

During 2000-01, 350 hospitalizations occurred per 100,000 of the Nova Scotia population for conditions where appropriate primary or community-based care may have prevented the need for hospitalization, as compared to 370 per 100,000 Canadians overall. Provincially and nationally, ambulatory care sensitive condition scores have decreased over the last 6 years reflecting a consistent positive trend towards improved access to primary care services.

Where Do We Want to Be in the Future?

Nova Scotia is aiming to limit the proportion of people admitted to hospital for ambulatory care sensitive conditions to levels consistent with the Canadian average. Towards this end the Department of Health will continue to monitor the effective utilization of hospital beds and review opportunities to use outpatient and primary care services most effectively.

Percentage of Health Human Resource Positions (doctors, nurses, etc) Filled in Under-served Areas

One of the Department of Health's core business areas is Insured Health Programs which includes the services of many health care professionals. A desired outcome in this area is access to quality health care. One way to enhance access is by ensuring the appropriate number and distribution of health care providers.

What Does the Measure Tell Us?

One measure of the supply and distribution of health personnel is the percentage of primary health human resource positions filled in underserved areas. Underserved areas are defined as those that have a history of recruitment and retention difficulties, where recruiting by local committees has been unsuccessful for more than six months, and where the medical needs of the community are not being otherwise served. Those areas that are designated as 'underserved' have incentive programs to support physician recruitment. The total number of underserved areas can change over time. In February 2002, the number of underserved areas (communities with vacant physician positions) was defined as 44 communities throughout Nova Scotia.

Where Are We Now?

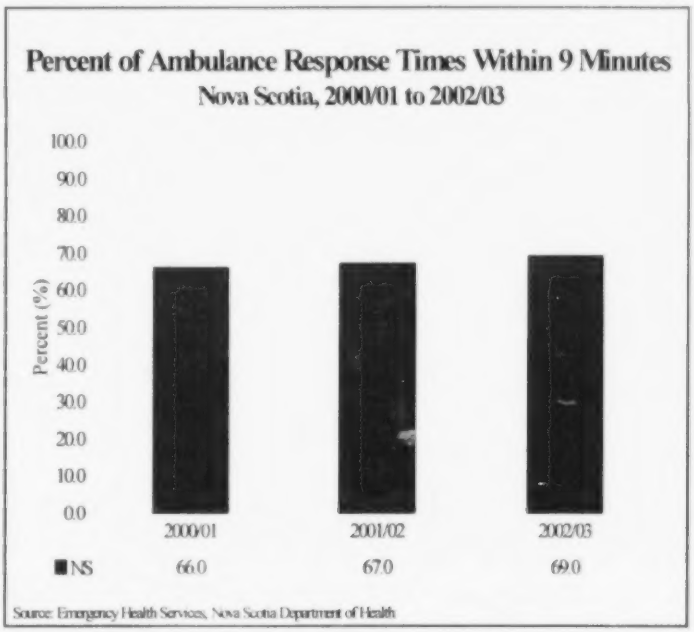
In February 2003, all but 7 of the 44 physician positions were filled in underserved areas (84%). The total number of physicians in underserved areas changes rapidly because of natural fluctuations (deaths, retirements, and the voluntary relocation of providers within the province) and successful recruitment. Ongoing recruitment efforts are required to maintain or exceed the provincial target (80%). More jurisdictions in Canada are engaging advanced practice nurses and non-physician providers throughout the health care system to enhance access to quality health care. Nova Scotia is continuing with a pilot project in Long and Brier Islands in which paramedics and a nurse practitioner work in close collaboration with a physician to provide primary care services. In addition, the Department is engaged in health human resource planning to address the supply and distribution of health professionals and other workers across the province.

Where Do We Want to Be in the Future?

Nova Scotia's target is to have 80% or more health human resource positions filled in underserved areas of Nova Scotia. The Department of Health has continued to support physician recruitment initiatives throughout the province through web site listings of vacancies, a recruitment guide, advertising, and incentives.

Percentage of Response Times at 9 Minutes or Less from Ambulance Dispatch to Arrival at Emergency Scene

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is access to quality emergency health services. One of the ways in which this outcome may be assessed is by calculating response times from ambulance dispatch to arrival at the emergency scene.



What Does the Measure Tell Us?

The industry standard for response time from ambulance dispatch to arrival at the emergency scene is 9 minutes or less 90% of the time for urban/densely populated areas. This standard is based on chances on the survivability of cardiac arrest patients. The lower the response time interval, the greater the chance of survival.

Where Are We Now?

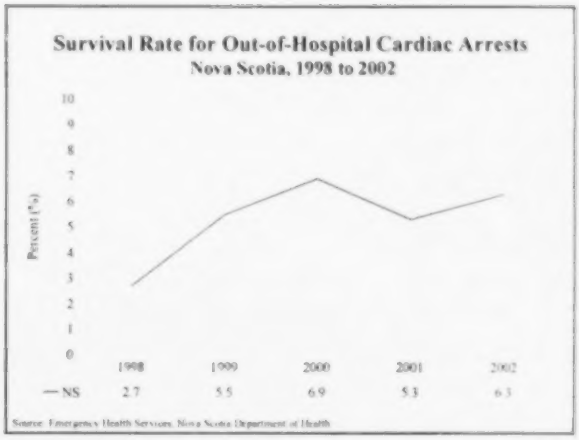
In 2002-03, for 69% of all emergency calls in the province, ambulances arrived at an emergency scene in 9 minutes or less. For calls in urban/densely populated areas, ambulances arrived at an emergency scene 90.07% of the time in 9 minutes or less. This performance is an increase over 2001-02.

Where Do We Want to Be in the Future?

The Nova Scotia government has defined a target of 68% (by 2004-05) for response times of 9 minutes or less from ambulance dispatch to arrival at the emergency scene. This target is for all emergency calls in the province.

Survival Rates for Out-of-hospital Cardiac Arrests

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is ensuring the effectiveness of emergency health services.



What Does the Measure Tell Us?

The effectiveness of emergency health services may be measured by calculating survival rates for those individuals who suffer cardiac arrests outside of hospital. Many factors affect out-of-hospital cardiac arrest survival such as the availability of timely and skilled intervention.

Where Are We Now?

In 2002, survival rates for out-of-hospital cardiac arrests were 6.3%. Because of the relatively small numbers, this is within the normal year-to-year variation. It is difficult to compare Nova Scotia's system with similar systems because of the different mix of urban and rural jurisdictions in other provinces. However, it is possible to compare Nova Scotia's out-of-hospital cardiac arrest survival rates over multiple years. An examination of Nova Scotian out-of-hospital cardiac arrest survival rates over multiple years shows that 2002 rates have increased over 1998 rates.

Where Do We Want to Be in the Future?

Nova Scotia's goal is to improve survival rates for out-of-hospital cardiac arrests over time. Strategies to achieve this target include maintaining training, ongoing procedural review and development, and exploring the development of a bystander care initiative.

Percentage of the Population (Aged 15 or Older) Receiving Homemaking, Nursing or Respite Services.

One of the Department of Health's core business areas is Continuing Care Services. A desired outcome in this area is ensuring access to quality Home Care and Long Term Care Services. Access to long term care and home care services may be measured by estimating the percentage of the population (age 15 or over) who receive homemaking, nursing, or respite services.

In recent years, the Department of Health has supported programs to deliver some health services to people in their homes as an alternative to admitting people to acute care or long term care facilities. This has numerous benefits. For example: people needing care are more comfortable, and their life styles and independence are maintained for as long as possible; facility space can be reserved for those with greater health care needs; lower costs are often associated with home care, compared to care in institutions.

What Does the Measure Tell Us?
As more home care programs are implemented, it is expected that these services will be provided to increasing numbers of people. Estimating the percentage of the population (aged 15 years and over) that receives homemaking, nursing or respite service helps us to understand growth in, and access to, quality Home Care and Long Term Care Services.

Where Are We Now?
Approximately 2.6% of Nova Scotians responding to the survey in 2000-01 indicated that they had received Home Care and Long Term Care Services (Canadian Community Health Survey, Statistics Canada). This is comparable to rates in the other Maritime provinces.

Where Do We Want to Be in the Future?
It is our goal to ensure that Nova Scotians have appropriate access to home care services. More data are required before a formal target can be set. We have established a Single Entry Access so that clients receive a single entry to Home Care or Long Term Care services.

Percentage of All Patient Days Spent in Hospital Accounted for by Patients with Serious Mental Illness

One of the Department of Health's core business areas is Mental Health Services. A higher overall proportion of patient days accounted for patients with serious mental illness flags success in shifting service options from inpatient to alternate settings for appropriate clients and achieving more appropriate use of inpatient hospital care.

What Does the Measure Tell Us?

Persons with serious and persistent mental health problems are those who benefit most from hospital admissions. However, other individuals, for whom outcomes are not enhanced by hospital care, may also be admitted to hospital because alternative community-based services or supports are not available. With limited inpatient capacity, this may reduce the availability of hospital care for those who need it most. The percentage of all patient days spent in hospital accounted for by patients with serious mental illness is calculated by dividing the number of patient days on designated psychiatric inpatient units for patients with serious mental illness by the total number of patient days on designated psychiatric inpatient units.

Where Are We Now?

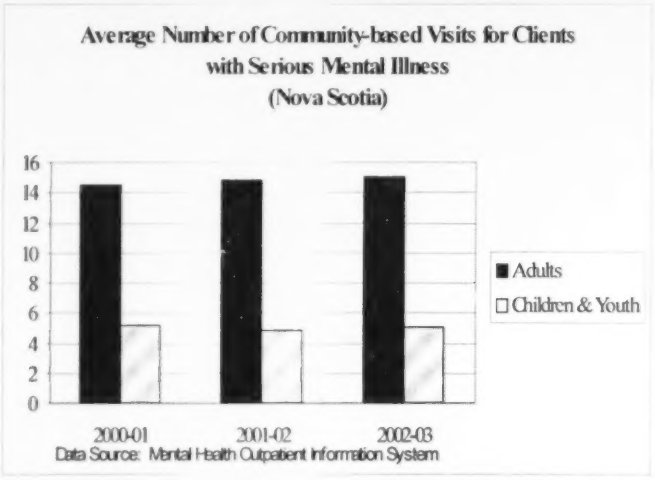
In 2002-03, the percentage of patient days for patients with serious mental illness was 72.7%, which is fairly consistent with percentage since 1999-00.

Where Do We Want to Be in the Future?

The Department of Health has a target of 75% by 2004-05. The strategy to reach this goal is to continue to support shifting service options from inpatient hospital care to alternate settings where appropriate.

Average Number of Community-based Visits for Clients with Serious Mental Illness

One of the Department of Health's core business areas is Mental Health Services. With the move from acute to community-based care for people with mental illness, a desired result is an increase in the average number of community-based visits for clients with serious mental illness.



What Does the Measure Tell Us?

This measure describes the average number of community-based visits to clients, both adult and children and youth, with serious mental illness. It is also a reflection of the move toward successfully supporting people with severe and persistent mental illness in achieving the highest level of functioning possible in the least restrictive setting.

Where Are We Now?

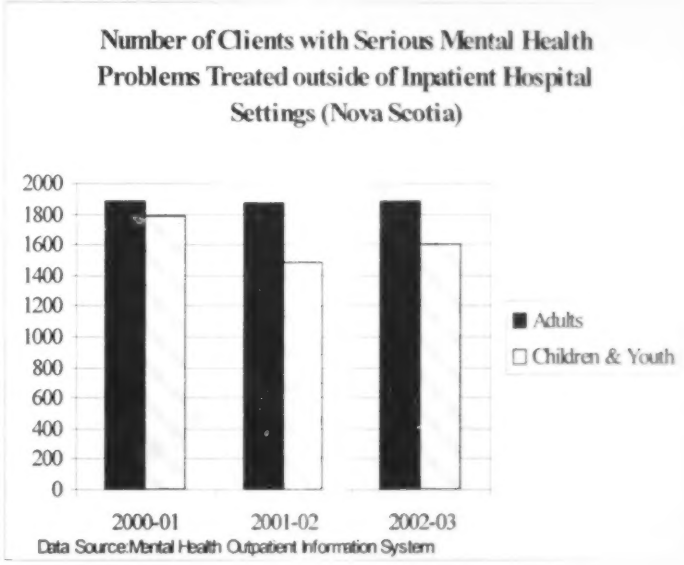
In 2002-03, there were an average of 15.0 community-based visits for adults and 5.0 for children and youth. For adults, this is consistent with the previous two years of data, but the trend for children and youth with serious mental illness is less consistent.

Where Do We Want to Be in the Future?

For 2004-05, the targets are for an average of 15.5 community-based visits for adults and 6.0 for children and youth. To reach these goals, the Department of Health is focussing on improving its ability to identify individuals who would benefit and increasing resources for community-based services.

Number of Clients with Serious Mental Health Problems Treated Outside of Inpatient Hospital Settings

One of the Department of Health's core business areas is Mental Health Services. A desired result is identifying individuals who can appropriately reside in the community and providing community-based services and supports that suit their needs.



What Does the Measure Tell Us?

In most jurisdictions, there is a move from acute to community-based care for people who suffer from mental illness. Increasingly, people with severe and persistent mental illness are being supported in achieving the highest level of functioning possible within the least restrictive setting. This requires an array of treatment alternatives to inpatient hospitalization and the necessary supports to keep people well and living in their communities. This measure shows how many adults and children and youth with serious mental health problems are treated outside of the inpatient hospital settings.

Where Are We Now?

In 2002, 1887 adults and 1600 children and youth with serious mental illness were treated outside of inpatient hospital setting. For adults, this is consistent with the previous two years of data, but the trend for children and youth with serious mental illness is less consistent.

Where Do We Want to Be in the Future?

For 2004-05, the targets are for 2100 adults and 1970 children and youth suffering with serious mental illness to be treated in community-based settings. To reach these goals, the Department of Health is focusing on improving its ability to identify individuals who would benefit and increasing resources for community-based services.